reaction. This is done through inhibiting allergic mediator release as well as inactivating these chemical mediators.

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REFERENCES

Hubscher T: Role of the eosinophil in the allergic reaction—I. EDI—An eosinophil-derived inhibitor of histamine release; II. Release of prostaglandins from human eosinophilic leukocytes. J Immunol 114:1389-1393, Apr 1975

Goetzl EJ, Wasserman SI, Austin KF: Eosinophil polymorphonuclear leukocyte function in immediate hypersensitivity. Arch Pathol: 99:1-4, Jan 1975

Wasserman SI, Goetzl EJ, Austen KF: Inactivation of slow reacting substance of anaphylaxis by human eosinophil arylsulfatase. J Immunol 114:645-649, Feb 1975

The Early Detection of Childhood Asthma by History

THE TERM ASTHMA may refer to a single episode of wheezing, coughing and difficult breathing due to obstruction of the airway by bronchospasm, mucous membrane swelling and mucus secretions. It is also a term for a constitutional characteristic of some allergic persons in whom allergy periodically presents in this way. These people are referred to as "asthmatic."

Most of such persons consider themselves free of respiratory problems except for an occasional attack of asthma. Closer examination of their history, however, often shows evidence of a minor degree of respiratory tract allergy which is present much or even most of the time.

Detection of such minor symptoms often is the key which permits recognition of the probable asthmatic nature of what otherwise might be diagnosed as bronchitis, pneumonia, bronchopneumonia, bronchoiolitis or even croup.

The minor symptoms include coughing at night, coughing or occasional wheezing on exertion, an above average amount of sneezing and itching, postnasal drainage and rubbing of the nose. Although the latter symptoms are not directly linked with asthma, they are reliable signs of allergy in the upper airway which may signal accompanying allergy in the lower airway—that is, asthma.

Coughing at night (even though it may not awaken the patient) and coughing, dyspnea or wheezing on exertion are even more often signals of an underlying respiratory allergy. Early search for these clues in a patient's history is important since one may then proceed to look for their causes in order to prevent further episodes of asthma which will otherwise occur. It also puts into focus the noncontagious nature of the patient's disorder and explains why dependence on antimicrobial therapy may be unsatisfactory.

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REFERENCE

McFadden ER: Exertional dyspnea and cough as preludes to acute attacks of bronchial asthma. N Engl J Med 292:555-559, Mar 1975

Nasal Polyps and Allergy

ON TRANSNASAL EXAMINATION of the nose, nasal polyps are seen as grey, pearly-white excrescences. Occasionally they may not be seen anteriorly and may be viewed only on nasal-pharyngeal examination. Polyps are not true neoplasms. Histologically they are lined with columnar epithelium and contain the same elements as nasal mucosa. There is a pronounced variability in content of edema fluid and eosinophils. The pathogenesis of polyps is not clear. They are associated with allergic rhintis, infectious sinusitis, cystic fibrosis and aspirin sensitivity—the last usually associated with bronchial asthma.

Although eosinophilia is a hallmark of atopic disease, it is quite variable in polyps. In fact, it does not distinguish the atopic from the nonatopic state. Intense eosinophilia may be seen in an aspirin-sensitive, severe nonatopic asthmatic, while eosinophils may be sparse in polyps from a young, moderately allergic patient. However, those from atopic patients do contain large amounts (10 to 40 percent) of immunoglobulin E producing cells not seen in nonatopic patients.

Treatment is symptomatic and is designed to improve the nasal airway and prevent occlusion of the ostia of the maxillary sinuses. Chronic maxillary sinusitis is not an infrequent accompaniment of nasal polyposis. Dexamethasone, self administered by intranasal spray, will produce considerable reduction in polyp size—particularly in small polyps. If this treatment is not successful, surgical intervention is necessary but should be undertaken with the knowledge that polyps frequently recur.

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REFERENCES

Whiteside TL, Rabin BS, Zetterberg J, et al: The presence of IgE on the surface of lymphocytes in nasal polyps. J Allerg Clin Immun 55:186-194, Mar 1975

Samter M: Intolerance to aspirin. Hosp Pract 8:85-90, Dec 1973

Samter M: Nasal polyps: An inquiry into the mechanism of formation. Arch Otolaryngol 73:334-341, Mar 1961